State Mental Health Commissions:

Recommendations for Change and Future Directions

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We would like to express our appreciation to the Florida Mental Health Institute (FMHI) that co-sponsored the national meeting and has been instrumental in the production of this report. Nancy N. Bell, Ph.D. and David L. Shern, Ph.D., Dean (FMHI), the authors of this report have moved this project forward from its inception.

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Introduction

Treatable mental illnesses plague almost every setting in our communities, as clearly described in the landmark 1999 Surgeon General's report on mental health (U.S. Department of Health and Human Services, 1999). Schools, penal institutions, juvenile justice facilities, child protection services, public welfare systems, nursing homes, and health care settings are all struggling to meet their primary missions in the face of the mental health problems confronted by their constituents. While families continue to be devastated by disorders that can be successfully treated, treatment may not be accessible or affordable.

Our community response to these problems is often inadequate. Although the public mental health system in the United States has many strengths, numerous weaknesses also exist. This report is a rallying cry for a much needed, rapidly-implemented change on the federal, state, and local levels that will build on system strengths and address weaknesses.

Consider these concerns:

- Although millions of Americans rely on public mental health services, thousands of people in need do not have access to these services. Children and older adults are particularly underserved (Bazelon Center for Mental Health Law, 2001). The lack of outreach to people with mental health problems where they live, work, gather, or go to school, and the absence of preventive and early intervention services, exacerbates problems leading to devastating personal and societal consequences.

- Stigma, discrimination, and the lack of insurance coverage for mental illnesses continue to inhibit access to care for many Americans.

- A lack of community mental health care has led to widespread, inappropriate use of hospital emergency departments, crisis stabilization units, and institutional and residential care, including jails, prisons, and juvenile justice facilities.

- Our nation's prisons have become, in effect, our largest mental hospitals. In many states, a greater number of individuals with severe mental illness are incarcerated than are hospitalized in state psychiatric facilities. Proven community care strategies exist to keep many of these individuals from entering correctional settings but they are not widely available.

- Desperately needed support and rehabilitation services (housing, transportation, employment, disability benefits, health care, etc.) are often not available, especially for persons with severe mental illness. The lack of support services results in an exacerbation of symptoms and leads to higher costs than would have occurred had adequate support services been available.

- Billions of dollars are spent on public mental health across multiple sectors, but funds are often disproportionately allocated to deep end, intensive services. At the same time, many critical prevention and early intervention programs are under-funded.

Our current dilemma is complex, but the desired result is simple—to assure the public's health. Accessible, comprehensive mental health services for all those in need comprise an integral part of the solution. Policy makers and communities must comprehend both the inefficiency and lack of resources in our current approach and begin to develop a collective commitment to change.

As part of the work of the legislatively created Florida Commission on Mental Health and Substance Abuse, the Florida Mental Health Institute (FMHI) worked with the National Association of State Mental Health Program Directors (NASMHPD) to identify states that had current or recently completed commissions. Thirteen commissions, 10 temporary and 3 standing, were identified. FMHI reviewed reports from the state commissions of Arizona, California, Connecticut, Florida, Indiana, Kentucky, Montana, Nevada, Ohio, Tennessee, Virginia, West Virginia, and Wisconsin. The following common themes were identified:

- Accountability and outcomes
- Consumer issues
- Criminal and juvenile justice issues
- Funding and access to older adult and children's mental health services
- Leadership and innovation
- Mental health law
- System design

Recognizing the potential value to future state and national agendas of a consensus-oriented dialogue among state commission representatives, a meeting was held on January 28-29, 2002 in St. Petersburg, Florida. The meeting brought together representatives from each of the 13 state commissions and 8 national experts. In preparation for the meeting, the experts reviewed the state commission documents and synthesized these reports in relation to one of the organizing themes listed above. They also noted issues related to the themes that were not included in the reports.

In discussion following each expert's presentation, the group reconstructed the collective thinking of the state mental health commissions and reached consensus on the most important unifying themes. This report is a summary of the meeting's content and discussion.

Key Tensions

During discussion of the commonalities and differences among states and the development of new directions and strategies, certain key tensions emerged. These dichotomous issues must be addressed as national, state, and local solutions are developed.

Bold Plan vs. Realistic Objectives

Public policy makers often must choose between crafting a bold plan with a broad scope and ambitious goals and a more focused strategy with tighter, more realistic objectives. Whether through a bold plan or realistic objectives, a sustained effort and action strategies should be built into the process to ensure continuity.

Federal/State Leadership vs. Local Initiatives

Public mental health has often struggled to find a balance between the broad vision and direction of national and state leadership and those local initiatives behind many innovative solutions. This dichotomy can be closely related to a long-standing tension between centralized control and decentralized action.

Science/Evidence vs. Practice/Policy

A growing insistence on evidence-based practice in mental health care is reflected in the tension between documented, science-based interventions and the practical problems of implementing these interventions in complex, real world settings.

Prescriptive Treatments vs. Outcomes Evaluation

A tension exists between attempting to control the quality of services through monitoring the processes of care, as contrasted with an emphasis on documenting the outcomes of care.

Deliberate Scientific Evaluation vs. Swift Political Action

It can be difficult to address the legitimate need for rigorous, time-consuming, scientific evaluation of treatment modalities with the desire of public policy makers and mental health advocates for swift, opportunistic action to improve the public mental health system.

Insider vs. Outsider Perspectives

The concerns of consumers and advocates for individuals with mental illnesses, based on their experiences, sometimes conflict with those of the policy makers charged with making decisions that affect their lives. Often professionals and state policy staff interpret mental health services in ways that may

not be meaningful to the public at large. Should mental health policy be driven by bureaucratic perspectives or by broader public concerns? Can't both be accommodated?

Targeted Populations vs. Integrated Perspectives

Focusing on particular populations defined by age, diagnosis, or other personal or social characteristics can lead to categorically-oriented funding that frustrates the integration of care—leading to the "silo" effect that currently characterizes the public mental health system.

Coordinated Programs vs. Entrepreneurial Solutions

A more traditional approach to coordinating programs within the established structure of the public system can clash with innovative entrepreneurial solutions.

While acknowledging these important dilemmas and the need to address them, meeting attendees agreed on the following key points:

- Mental health is an integral part of public health and of public health policy, and should be treated as such.

- Our national goal should be accessible, effective mental health care for all citizens.

- Healthy, productive families and communities should be an expectation of every citizen, reflected in common discourse, policy, and practice, including:

    - Accountable leadership at the local, state, and federal levels;

    - Destigmatizing mental illnesses in the public's consciousness, as has occurred with cancer and AIDS;

    - Effective public and consumer/family education to increase recognition of treatable conditions and create demand for effective services; and

    - A shared recognition that mental illness occurs in many families and affects us all.

Consensus Themes

State mental health commissions have been vehicles for positive change. Their findings and subsequent recommendations have resulted in improvements in public mental health systems. In discussion following the meeting's expert presentations, consensus was reached on the following themes:

Mental health care should be an accepted public value with a clear set of expectations related to an individual's health, family well being, and the public good.

California's report said it best, "What sets mental health apart from other social and medical causes is that we do not share a collective expectation or sense of responsibility—and as a result, there is little outrage when mental health programs fail." (Little Hoover Commission, 2001). Our national and state mental health policies and systems are in critical condition largely because of the absence of this sense of responsibility. Put simply, mental illnesses make us uncomfortable, so we have failed to protect and help those who suffer from them. This societal discomfort is reflected in our public policies and in mental health laws that often reflect discrimination rooted in stigma. We don't know what to expect of our public mental health system, so we expect very little—and that is what we, and the millions of individuals and families who rely on the system, often receive.

Action

Mental illnesses must be destigmatized and better understood by the general public. New approaches to public education must be devised. Partnerships should be formed with community leaders who have not traditionally understood or championed mental health issues. Achievement of this goal requires clear national objectives and creative communication strategies. Mental health is everyone's concern, not the burden of an unfortunate few. Americans must be convinced that mental illnesses and substance abuse problems affect them and their families. Nearly every American family has members who suffer—or have suffered—from mental illness or substance abuse. Unfortunately, this is neither a comfortable nor a widely discussed fact.

We also must create public awareness that mental health treatments are as effective as other well-accepted medical treatments. When we acknowledge that mental health is our collective priority and that effective treatments are available, we will create a strong public impetus for workable solutions.

As a public value, mental health must be accepted as integral to public health policies and practice, with improved assessment at the primary care level and referral to appropriate specialty care.

Effective mental health treatment should be available in natural helping settings, such as primary health care and schools. Strengthening the availability of mental health services in primary care will help to reduce stigma by educating individuals and families about a variety of mental disabilities, effective treatments, and appropriate helping professionals. When primary care patients are routinely screened

for mental and behavioral health problems (including substance abuse), misunderstandings and fears about their problems could be reduced and we become better educated about the role of mental health in their overall well being. For example, this approach might parallel ways individuals are currently educated about improving cardiovascular health by eliminating risk factors (e.g., smoking) and promoting healthful behaviors (e.g., exercise).

Action

Far more emphasis should be placed on prevention and early intervention. Prevention has historically received little attention in public mental health yet should be closely tied to public education and political/policy leadership.

Similarly, in terms of early intervention, at least half of all persons with mental disabilities do not seek treatment (U.S. Department of Health and Human Services, 1999). As a result, symptoms worsen and problems become more severe and disabling. Why do so few people seek treatment? They may not understand or recognize the symptoms of a mental illness, know how or where to receive help, or know that effective treatments are available. They may be reluctant to seek help because of the stigma of mental illness or encounter financial or other access barriers. We need public education about the nature and treatment of these disorders and evidence-based prevention interventions, coupled with political leadership, to address financial barriers to care.

As part of a public health model, early intervention into developing problems could be achieved through primary care health screening and identification within families, at work, school, or in a variety of other settings where people congregate. If needed, referral to appropriate help could then follow, with specialized assessment and treatment occurring in community settings.

New hope and optimism exist in mental health due to scientific advances in the past 25 years, including effective, new treatments.

We have proven psychosocial techniques and effective medications to successfully treat most mental disorders. In fact, mental health problems have never been more treatable and manageable than they are today. With appropriate care, most individuals, even those with severe mental illness, can recover at least to the point of managing their illness and reintegrating productively into their communities.

Unfortunately, our practices lag behind our knowledge, both in treatment and service system design. We know what works, but the new science is often not used at the consumer level. A significant gap also exists between evidence and policy making.

Action

We need effective public education so that well-informed consumers can insist upon appropriate care. Public policies that reinforce evidence-based practices and strong state and local leadership are all part of the solution for bridging the knowledge/practice gap.

Many individuals and families experience significant barriers to services access. Unmet need exists in all age and consumer groups, especially in children, older adults, and culturally-diverse populations.

Many state systems are characterized by segregation and barriers to service rather than open access and integrated programs. With limited public resources, states try to provide services to those most in need, but thousands receive no care at all.

Action

A market-driven, consumer-centered system, coupled with an educated public, will provide evidence-based practices to all in need. We must stimulate the development of viable markets through strategies such as charter programs (similar to charter schools), voucher programs that empower consumers to select alternative services, report cards that help support informed decisions when choice exists, and the provision of venture capital to support the development of new approaches.

A significant amount of money is spent in the public mental health system, but funding is unevenly allocated and often inefficiently spent.

In spite of the amount spent, many essential mental health treatment and support services desperately need additional funding and/or a more efficient allocation system in order to serve all those who need care. State appropriations for mental health have been reduced sharply in nearly all states. In some states, mental health services is one of the lowest financial priorities. Multiple and often conflicting funding streams frustrate access for consumers.

In addition to limited funding for mental health care, funds for related support services are often not only limited but "trapped" in agencies that are outside the specialty system, leading to jurisdictional problems and competing claims. This "silo" effect has led to many non-mental health agencies attempting to provide mental health services in addition to meeting their primary objectives, resulting in inadequate services, poor quality, and a lack of interagency planning and coordination.

Recognizing that valuable resources for public mental health services were trapped in an oversized state hospital system, the Virginia commission enhanced public and political awareness that state facilities should be closed as well as created the expectation and a mechanism to redirect state facility funding to community services.

In many state systems, the money does not follow consumer needs. Instead, consumers receive whatever services are funded, too often resulting in inappropriate treatment and inefficient use of resources. In addition, an increased reliance on Medicaid-covered services for which states can claim matching funds has resulted in reduced funding for non-Medicaid services. The system's capacity shrinks when states fail to increase reimbursement rates to accommodate inflation.

Action

Adequate funding that is creative, flexible, and accountable is essential. The federal government needs to provide a national leadership model for improved agency integration and greater flexibility for the use of federal resources at the state and local levels. States need to provide localities with greater control over resource allocation. Incentives should be provided for achieving more fully integrated and coordinated systems of care.

The widespread criminalization of mental illness is due to obstacles and failures in emergency mental health services, a lack of identification and early intervention, and inadequate community-based resources.

A large number of individuals with mental illness are jailed for minor offenses due to a lack of community services and insufficient or the nonexistence of screening and assessment. Nationally, some 284,000 adults with serious mental illnesses are incarcerated annually (Bazelon Center for Mental Health Law, 2001). A high number of detainees have both mental illnesses and substance abuse problems. In effect, our jails and prisons are now our largest psychiatric facilities, assuming the role of provider of mental and behavioral health services to offenders. Even so, services within the criminal justice system are frequently inadequate or unavailable.

In Tennessee, however, their commission's report resulted in establishing seven local liaison positions to facilitate education, training, and coordination between mental health and criminal justice systems.

Action

Services must be expanded to better meet the needs of incarcerated persons with mental health disorders, and greater emphasis should be placed on developing diversion programs to reduce inappropriate incarceration. Coordinated planning and transitional services are needed to more effectively integrate offenders leaving prisons and returning to community care. Finally, better training in identifying and responding to individuals with mental health issues must be provided to law enforcement, attorneys, judges, and others who interact with these persons.

Juvenile justice systems are similarly affected but have received minimal attention until recently. However, state juvenile justice directors maintain that children with mental health issues are their number one concern (Cocozza, J.P., 2002). Perhaps nowhere is the need for prevention, early intervention, and coordinated services more pressing than in juvenile justice.

Given the decreasing dominance of state mental health authorities, strong, new system-wide leadership is required.

Many states report the sense of a leaderless public mental health system that is too diffuse and unfocused to be effective. This does not imply the desirability of a superagency but instead that some public entity should take a leadership role in mental health. We need far better coordination, service integration, and information sharing across multiple service settings and throughout all levels of government.

Florida's mental health commission recommendations resulted in the revision of state statutes regarding the care of individuals with serious and persistent mental illnesses. Two large, multi-county demonstration projects were created to implement treatment recommendations for this population. A workgroup was also established to explore barriers to interagency cooperation also resulted from commission recommendations.

Following the Connecticut commission's work, the Governor created a Mental Health Policy Council to track the implementation of the commission's recommendations. Subsequently, a 14-member Community Mental Health Strategy Board was formed to produce a community mental health strategic plan as well as financial plan to support the initiatives. Ten key priorities underlying the plan were drawn from the commission's report.

Action

While new federal and state leadership should be developed and encouraged, local and informal leadership is also important. We must realign responsibilities to create meaningful system change, ultimately achieving an effective balance between centralization and decentralization. Funding should be aligned with accountability, and innovative projects should be supported with adequate funds.

As a field, we need to systematically address the development of leadership. Our human resources are key but are often not nurtured. A contemporary version of the National Institute of Mental Health (NIMH) staff college may be required for human resource development. Higher education also plays a role and should be provided incentives to improve the relevance and availability of leadership education.

Among the key components of the current mental health system, federal leadership and funding are essential for the additional development of data integration and utilization strategies at the local level. These strategies must focus on the use of existing data rather than on the creation of new data collection mechanisms.

Goals

Discussion at the January meeting among the state commission representatives and national experts culminated in these goals for system improvement:

- Be clear regarding objectives.
- Keep objectives simple, few in number, and citizen-focused.
- Choose outcomes that everyone can support.
- Develop new leaders on the national, state, and local levels.
- Cultivate new allies, forge partnerships, and incorporate creative new perspectives.
- Develop new or expanded sources of funding to address unmet need.

Conclusion

We must improve mental health services to all who need help as early in their lives or illness as their concerns can be identified. Clearly, the old means of reaching desirable ends have not worked. A mental health "system" has developed with vague boundaries involving multiple health, education, criminal justice, and social service settings. Persons with mental illness are seen throughout this system yet often they do not receive the services they need to participate as healthy members of their communities. Meanwhile, their untreated illness confounds the ability of these human service settings to accomplish their primary missions.

The current critical condition of our de facto state mental health systems calls for dramatic new strategies focused on the real needs of individuals, families, and communities affected by treatable mental illness. We need clear expectations for mental well being, shared responsibility in achieving these ends, and perhaps most importantly, the political will to change existing approaches.

Our challenge is to develop innovative relationships at the local, state, and federal levels as well as among the major government sectors that promote the recognition of a new system. We also must develop technologies—information, treatment, and financial—that reflect contemporary realities. Together, we must create a mental health system that meets the needs of individuals and families proactively, efficiently, and economically, allowing the public the opportunity to participate fully in their community and live a productive, healthy life.

References

Bazelon Center for Mental Health Law. (2001). *Disintegrating Systems: The State of States' Public Mental Health System.* Washington, D.C.

Cocozza, J.P., Ph.D. (2002). *Presentation at the State Mental Health Commissions Meeting.* Delmar, NY: National Center for Mental Health and Juvenile Justice, Policy Research Associates.

Little Hoover Commission. (2000). *Being There: Making a Commitment to Mental Health.* Sacramento, CA: Little Hoover Commission.

U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General-Executive Summary.* Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Appendices

Appendix A:

State Mental Health Commissions Meeting
Agenda

State Mental Health Commissions: Recommendations for Change and Future Directions

January 28-29, 2002
Don CeSar Beach Resort and Spa
St. Petersburg, FL

Sponsored by:
Center for Mental Health Services (CMHS),
Substance Abuse and Mental Health Services Administration (SAMHSA)
Florida Mental Health Institute (FMHI), University of South Florida (USF)
National Technical Assistance Center for State Mental Health Planning (NTAC),
National Association of State Mental Health Program Directors (NASMHPD)

7:30 AM – 8:00 AM	**Continental Breakfast**
8:00 AM – 8:30 AM	**Welcome, Overview and Goals** *David Shern, Ph.D.,* Dean and Professor, Florida Mental Health Institute *Robert W. Glover, Ph.D.,* Executive Director, National Association of State Mental Health Program Directors
8:30 AM – 9:00 AM	**Opening Remarks** *Charlie Curie, M.A., A.C.S.W.,* Administrator, Substance Abuse and Mental Health Services Administration
9:00 AM – 10:15 AM	**Leadership and Innovation** *Howard Goldman, M.D., Ph.D.,* Research Project Director, NASMHPD Research Institute, Inc.
10:15 AM – 10:30 AM	**Break**
10:30 AM – 11:45 AM	**Accountability and Outcomes** *Laurie Flynn,* Senior Research and Policy Associate, Columbia University
11:45 PM – 12:45 PM	**Lunch**

12:45 PM – 2:00 PM	**Mental Health Laws** *John Petrila, J.D.,* Professor and Chair, Department of Mental Health Law and Policy, Florida Mental Health Institute
2:00 PM – 3:15 PM	**Emerging Issues in Consumerism** *Laura Van Tosh,* Consultant
3:15 PM – 3:30 PM	**Break**
3:30 PM – 4:45 PM	**Funding and Access to Children and Family Services** *Robert Friedman, Ph.D.,* Professor and Chair, Department of Child and Family Studies, Florida Mental Health Institute
4:15 PM – 5:30 PM	**Synthesis of Day I**
5:30 PM	**Adjourn**

Tuesday, January 29, 2002

8:00 AM – 8:30 AM	**Continental Breakfast**
8:30 AM – 9:45 AM	**Funding and Access to Older Adult Services** *Larry Dupree, Ph.D.,* Chair, Department of Aging and Mental Health, Florida Mental Health Institute
9:45 AM – 10:00 AM	**Break**
10:00 AM – 11:15 AM	**Emerging Structure of the Contemporary Public Mental Health System** *Martin Cohen, Ph.D.,* President and CEO, MetroWest Community Healthcare Foundation
11:15 AM – 12:30 PM	**Criminal and Juvenile Justice Issues** *Joseph Cocozza, Ph.D.,* Director of Policy Research, Policy Research Associates, Inc.
12:30 PM – 2:30 PM	**Synthesis of Day II**
2:30 PM	**Adjourn**

Appendix B:

State Mental Health Commissions Meeting
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